MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00320

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryto

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1821 Abbott Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Pearl Priscilla Adylotte

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 29, 1928

8. AGE: Years	Months	Days	If less than one day
19	3	24	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Willie Howard
13. Birthplace: Unknown

MOTHER
14. Maiden name: Beatrice Adylotte
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Jan 26 1948. (month) (day) (year)

Cemetery or crematory: Gut. Calvary Cem.

Location: Baltimore, Maryland.

18. Funeral director: Mrs. O. Franley A. Hensley.

Address: 548 W. Biddle st.

19. Jan. 22 19 48 (Date rec'd by registrar) Albert R. Smaukhen Registrar
Local Deputy

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: January 22 19 48 at 5:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 19 48 to January 22 19 48 and that I last saw h...er alive on January 22 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 1/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00321

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mons. 10 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Linden P.O. Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
BUSTER ASKINS

3. (b) Social Security Number
213-16-0736

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 17, 1910

8. AGE:

Years	Months	Days	If less than one day
37	4	4	hrs. min.

9. Birthplace Brookeville, Montgomery, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Charles Magruder
13. Birthplace Maryland

MOTHER
14. Maiden name Susie Askins
15. Birthplace Maryland

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24 1948 (month) (day) (year)
Cemetery or crematory Sunset Memorial Park
Location near Silver Spring
18. Funeral director Robert L. Snowden
Address Rockville, Md.

19 Jan. 21, 1948 (Date rec'd by registrar) Albert R. Sunderland Registrar
Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1947 to Jan. 21 1948 and that I last saw him alive on January 21, 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	May 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben D. Foreman, M.D.
M. D. or other
Address Henryton, Md. Date signed 1-21-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138

00322

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Fredrick Sellus Butler

3.(b) Social Security Number 220-16-0075

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife Elizabeth Butler

6.(c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) March 17, 1917

8. AGE:

Years	Months	Days	If less than one day
30	9	30	....hrs. ....min.

9. Birthplace Wakefield, Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name Walter E. Butler

13. Birthplace Maryland

MOTHER

14. Maiden name Macey Black

15. Birthplace Maryland

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/19/48 (month) (day) (year)

Cemetery or crematory Western Cabel Cem.

Location Westminster, R. D. 6

18. Funeral director C. W. Zepp & Son

Address Union Bridge, Md. Westminster Md.

19. Jan. 16 1948 (Date rec'd by registrar) Albert R. Swanhart Registrar Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1948 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26 1947 to January 16 1948 and that I last saw him alive on January 16 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 9, 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben O. Swan M.D. M. D. or other

Address Henryton, Maryland Date signed 1/16/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00323

938

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 9 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 month, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Thurmont

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: OSCAR BRADEN CARR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWED

6.(b) Name of husband or wife: Lillian Eliza George (Deceased)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 5, 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57	0	10		

9. Birthplace: Loudon County, Virginia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Agriculture

FATHER — 12. Name: Peter Henry Carr

FATHER — 13. Birthplace: Loudon County, Virginia

MOTHER — 14. Maiden name: Roberta Elgin

MOTHER — 15. Birthplace: Loudon County, Virginia

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20 1948 (month) (day) (year)

Cemetery or ~~crematory~~: Union Cemetery

Location: Leesburg, Virginia

18. Funeral director: M. R. Etchison & Son

Address: Frederick, Md.

19. Jan 17 1948 (Date rec'd by registrar) C Harry Neer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 19 48, at 11:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6 19 48 to January 15 19 48

and that I last saw h im alive on January 15 19 48

	DURATION
Immediate cause of death: Hypertensive cardio-vascular disease	7 yrs.
Due to: Generalized arteriosclerosis	3½ yrs.
Due to: Cerebral hemorrhage	2 days
Other conditions: Psychosis with Cerebral arteriosclerosis	3½ yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 1/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13L

00324

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 240 W. Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Forrest Alonza Carroll Jr.

3.(b) Social Security Number: 214-16-7328

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 27, 1907

8. AGE: Years	Months	Days	If less than one day
40	10	7	hrs. min.

9. Birthplace: Rockville, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Forrest Carroll Sr.
13. Birthplace: Rockville, Maryland

MOTHER
14. Maiden name: Evelynn Carroll
15. Birthplace: Rockville, Maryland

16. Informant: Deceased
Address:

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan 6 1948 (month) (day) (year)
Cemetery or crematory: Rockville mem
Location: Lincoln Park
18. Funeral director: Robert L. Snouffer
Address: Rockville md

19. Jan. 3 1948 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: January 3 1948, at 7:01 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8 1947 Jan 3 1948 and that I last saw him alive on January 3 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 31, 1942
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 1/3/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

06325

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 6mos. 27 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or Institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war ....

3.(a) FULL NAME Sevellon Carroll

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife ....

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) April 18, 1901

8. AGE: Years	Months	Days	If less than one day
46	9		.... hrs. .... min.

9. Birthplace Rockville, Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ....

FATHER 12. Name Forrest Carroll

13. Birthplace Rockville, Md.

MOTHER 14. Maiden name Evelyn Carroll

15. Birthplace Rockville, Md.

16. Informant Deceased

Address ....

17. Burial (Burial, cremation, or removal) Which? Date thereof Jan 22 1948 (month) (day) (year)

Cemetery or crematory Rockville md

Location Hesting

18. Funeral director Robert S Snowden

Address Rockville md

19. Jan. 18 1948 (Date rec'd by registrar) Albert R. Sandberg Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH January 18 1948 at 11:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1946 to Jan. 18 1948 and that I last saw him alive on January 18 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE Julien Hoffman M.D.
M. D. or other

Address Henryton, Maryland Date signed 1/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 00328 8 1

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Near Union Bridge, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: (Near) Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. 1
(If rural, give LOCATION)
2.(a) If veleran, name war

3.(a) FULL NAME: John William Carbendafner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Widowed

6.(b) Name of husband or wife: Mollie Selby Carbendafner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10-14-1860

8. AGE:

Years	Months	Days	If less than one day
87	3	13	..... hrs. ..... min.

9. Birthplace: Near Union Bridge, Md
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
FATHER 12. Name: John W. Carbendafner
13. Birthplace: Va
MOTHER 14. Maiden name: Elizabeth Blackston
15. Birthplace: Maryland
16. Informaot: Jessie Carbendafner
Address: Union Bridge Md RFD 1
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-29-48 (month) (day) (year)
Cemetery or crematory: Pipe Creek
Location: Near New Windsor Md
18. Funeral director: Raymond K. Wright
Address: Union Bridge. Md.
19. Jan 28, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1948, at 4:15 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1 1948, to Jan 27 1948
and that I last saw him alive on Jan 26 1948

Immediate cause of death	DURATION
Cortus Sclerosis	
Due to	
Due to	
Diher conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline tho cause to which death should be charged statistically.

22. VIOLENCE: If death was due to extereal causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. H. Legg M. D. or othor
Address: Union Bridge Date signed 1-28-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1st 00327

Reg. Dist. No. 74

W

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 29 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1904 Druid Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Alexander Chapman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 26, 1931

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
16	8	4		

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Charles Henry Chapman
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Lucy Waddy
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial. Date thereof Feb 3, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Mt. Wrayer

18. Funeral director: Mrs. Samuel T. Hensley
Address: 518 W. Biddle St.

19. Jan. 30 19 48 Albert R. Counselman
(Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION P.M

20. DATE OF DEATH: January 30 19 48 at 12:15

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 19 47 to January 30 19 48 and that I last saw him alive on January 30 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1947.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Wyman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 1/30/48

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

00328

Reg. Diat. No. 4D

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: County:

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George A. Clabaugh

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Catherine White Clabaugh

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1864

8. AGE: Years	Months	Days	If less than one day
83	4	28	hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER 12. Name: John Clabaugh

13. Birthplace: Md

MOTHER 14. Maiden name: Ann Spalding

15. Birthplace: Pa

16. Informant: Bernard J. Arnold

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2, 1948 (month) (day) (year)

Cemetery or crematory: St. Joseph's

Location: Taneytown, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. Feb 1, 1948 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30th 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26th 1948, to January 30th 1948 and that I last saw him alive on January 29th 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner M.D. M. D. or other

Address: Taneytown Md. Date signed: Jan 30, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00329

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mo. 27 da

Hospital, Institution, or street address (if not at home): Springfield State Hospital

How long in hospital or institution? 9 mo 24 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rosetta Coleman

3.(b) Social Security Number:

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Edward Coleman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 14 - 1869

8. AGE: Years: 78 Months: 5 Days: 4 If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER

12. Name: Aaron Duckworth

13. Birthplace: Md

MOTHER

14. Maiden name: Mary Ann Linsey

15. Birthplace: Md

16. Informant: Mrs John F Blubaugh

Address: Frostburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-22-48 (month) (day) (year)

Cemetery or crematory: Lonaconing

Location: Allegany Co., Md.

18. Funeral director: C. M. Eichorn

Address: Lonaconing, Md.

19. Jan 19 1948 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19th 1948 12-10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1947, to Jan 19 1948, and that I last saw h alive on Jan 18 1948

Immediate cause of death: Cerebral Hemorrhage Int.

DURATION

Due to: Int. Arterio Sclerosis 5 yrs

Due to:

Other conditions: Hypertension 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Martin M.D. M. D. or other

Address: Sykesville Md Date signed: 1/19/48

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

00330

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: SARAH V. CONDON

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1860

8. AGE: Years	Months	Days	If less than one day
87	2	27	..... hrs. ..... min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: William Condon
13. Birthplace: Maryland

MOTHER
14. Maiden name: Deborah Duvall
15. Birthplace: Maryland

16. Informant: Mrs. Pearl Thompson
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof 1-12-48 (month) (day) (year)
Cemetery ~~or crematory~~: Pine Grove
Location: Mt. Airy, Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 1/12, 19 48 (Date rec'd by registrar) Wm D Duryea Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10, 1948 19 ..... at 2 A; M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12, 1947 19 ..... to Jan. 10, 1948 and that I last saw her alive on January 9, 1948 19 .....

Immediate cause of death	DURATION
Chronic Myocarditis	? yrs.
Due to	
Due to	
Other conditions: advanced arterio-sclerosis	? yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt. Airy, Md. Date signed 1/10/48


JAN 13 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00331

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore- 30-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 518 S. Paca Street
(If rurol, give LOCATION)
2.(a) If veleran, name war Yes I

3.(a) FULL NAME ALONZO CONLEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorcsd
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1899

8. AGE: Years	Months	Days	If less than one day
48	11	19	hrs. min.

9. Birthplace Wilmington, N. Carolina
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Guy Conley
13. Birthplace N. Carolina

MOTHER
14. Maiden name Unknown
15. Birthplace N. Carolina

16. Informant Deceased
Address

17. Buried
(Burial, cremation, or removal. Which?) Date thereof Jan 12 48
(month) (day) (year)
Cemetery or crematory National Cemetery
Location Balto Md

18. Funeral director Walter B. Spriggs
Address 139 W Hamburg St

19. Jan. 9, 1948
(Date rec'd by registror) Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1948 at 5:30A M

21. I CERTIFY that death occurred on the date above stated; that I attendsd deceased from December 19, 1947, to January 9, 1948
and that I last saw him alive on January 9, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1947
Due to	
Due to	
Other conditions	

(Include pregnoney within 3 months of death)

Major fiodiogs of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the enose tu which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Msans of injury Injured at work?

23. SIGNATURE Reuben D. Swan, M.D.
M. D. or other
Address Henryton, Md. Date signed 1-9-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a BC 00332

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, writs RURAL and give nearest town)

How long in above place of death? 3 yrs., 11 mos., 19 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs., 11 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: ? (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mary Agnes Courtney

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1877

8. AGE: Years	Months	Days	If less than one day
70	1	1	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Jefferson J. Walsh

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Emma A. Gardner

15. Birthplace: Baltimore, Md

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 6 48 (month) (day) (year)

Cemetery or crematory: Cathedral Cemetery

Location: Baltimore Md.

18. Funeral director: H. W. Mears & Son

Address: Baltimore, Md.

19. Jan 3 19 48 (Date rec'd by registrar) C. Harry Mears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3, 1948 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15, 1947, to Jan. 3, 1948 and that I last saw her alive on Jan 3, 1948

Immediate cause of death	DURATION
Hypertensive cardiovascular disease	4 yrs.
Generalized arteriosclerosis	4 yrs.
Due to: Myocardial degeneration	4 yrs.
Due to:	
Other conditions: Involutional melancholia	4 yrs.
Fracture of nose: Was a bed patient because of involutional melancholia when she walked against a door, fracturing her nose.	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op. 1-6-48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Acc. Date of 1-3-48

Where did injury occur? Sykesville (City or town) Md. (State)

Injured at home, farm, industry, public place (where?) Springfield Hosp. (County)

Means of injury: Fall Injured at work? No

23. SIGNATURE: Joseph H. Marshall, M.D. M.D. or other

Address: Springfield State Hospital Date signed: 1/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct, age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00333

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cora E. Crawmer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: Walter F. Crawmer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 24 - 1872

8. AGE:

Years	Months	Days	If less than one day
75	3	30	hrs. min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At home

FATHER

12. Name: Lutherius Smith

13. Birthplace: Maryland

MOTHER

14. Maiden name: Susannah Black

15. Birthplace: Maryland

16. Informant: Walter F. Crawmer

Address: New Windsor Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 1/26/48 (month) (day) (year)

Cemetery or crematory: Custers Cemetery

Location: Union Bridge Rt. 2

18. Funeral director: H. H. Hartsock & Sons

Address: Union Bridge Rt. 2 Md.

19. Jan 25 1948 (Date rec'd by registrar) Emma S. Bunnell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1948 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1948, to Jan 23 1948 and that I last saw h~~im~~er alive on Jan 23 1948

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 1-23-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

137 BC 00334

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 1 month 13 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1018 Low Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Lucille Crier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Married

6.(b) Name of husband or wife: Thomas Crier
6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.): August 20, 1910

8. AGE: Years	Months	Days	If less than one day
37	4	17	..... hrs. ..... min.

9. Birthplace: Southern Pine, N. Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Harris
13. Birthplace: Petersburg, Virginia

MOTHER
14. Maiden name: Merlin Unknown
15. Birthplace: Petersburg, Virginia

16. Informant: Husband- Thomas Crier
Address 1018 Low Street, Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 10-1948 (month) (day) (year)
Cemetery or crematory Mt Calvary Cemetery
Location Dr C, Co Md
18. Funeral director Robert E Wyeth
Address 615 McElderry St

19. Jan. 6 1948 (Date rec'd by registrar) Albert R Swarbrick Registrar
Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1948 at 10:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24 1946 to Jan. 6 1948 and that I last saw her alive on January 6 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE Reuben W Owens, M.D.
M. D. or other
Address Henryton, Maryland Date signed 1/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00335

938

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Springfield State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 11 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 mos., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No. 904 Mantler Place
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Rachel Marcell Davis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 31, 1882

8. AGE: Years: 65 Months: 6 Days: If less than one day: hrs. min.

9. Birthplace: Frederick, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Isaac Davis
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden name: Sarah Frances Spalding
15. Birthplace: Frederick, Md.

16. Informant: Hospital records
Address:

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb 3 1948 (month) (day) (year)

Cemetery or crematory: St. Ignatius

Location: Urbana, Md.

18. Funeral director: M.R. Eckelmann & Son

Address: Frederick Maryland

19. Jan. 31 1948 (Date rec'd by registrar) A. Hardy Horn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31, 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20, 1947 to Jan. 31, 1948 and that I last saw h.. alive on Jan. 31 1948

Immediate cause of death	DURATION
Generalized arteriosclerosis	2
Arteriosclerotic heart disease	2
Due to: Myocardial degeneration	2
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph K. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date: 12/31/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

00336

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary E. Diggans

3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife Samuel Diggans
6. (c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 4, 1861

8. AGE: Years	Months	Days	If less than one day
86	6	3	... hrs. ... min.

9. Birthplace Deleware
(Town, county, and state)
10. Usual occupation House work
11. Industry or business Own home
FATHER 12. Name Isaac Melvin
13. Birthplace Deleware
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Mrs. George Shower
Address Taneytown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof January 9, 1948 (month) (day) (year)
Cemetery or crematory Methodist Cemetery
Location Hillsboro, Maryland
18. Funeral director C.O.Fuss & Son
Address Taneytown, Maryland.
19 Jan 7, 1948 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1948, at 5 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Cerebral hemorrhage	
Due to Hypertensive C-V. disease	2 yr +
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Marsh Deputy Medical Exam M. D. or other
Address Westminster Md Date signed 1-7-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

BC 00337

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs., 5 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 14 yrs. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

WILLIAM EBSWORTH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8/21/1885

8. AGE: Yeare	Monthe	Daye	If lese than one day
62	5	9	hrs. min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usuat occupation: Laborer & Decorator

11. Industry or business

FATHER 12. Name: David Ebsworth

13. Birthplace: Maryland

MOTHER 14. Maiden name: Georganna Crisk

15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1948 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md.

18. Funeral director: William Coore Inc.

Address: 1219 St. Paul St. Baltimore

19. Jan 31 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1948 at 11:40 A

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from January 25 1934 to January 30 1948 and that I laet eaw h... im alive on January 30 1948

Immediate cause of death	DURATION
Chronic myocarditis	5 yrs.
Due to: Generalized arteriosclerosis	5 yrs.
//// Cerebral hemorrhage	1 month
Bronchopneumonia	2 days
Other conditions: Dementia Praecox	13 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external cauees, fill in the following:

Accident, euicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, pub'lc place (where?)

Maene of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall M.D. M. D. or other

Address: Sykesville, Maryland Date signed 1/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00338

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 80

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary E. Fuller

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Emanuel Fuller

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 8 - 1875

8. AGE: Years: 72 | Months: 3 | Days: 22 | If less than one day: hrs. min.

9. Birthplace: Frederick County, Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: Isaac Eyler

13. Birthplace: Maryland

MOTHER

14. Maiden name: Margaret Sensenig

15. Birthplace: Maryland

16. Informant: Mrs. Edgar S. Barnes

Address: Uniontown, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb 1 - 1948 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: H. W. Hartzler & Sons

Address: Uniontown Road, New Windsor, Md.

19. January 31 1948 (Date rec'd by registrar) Essie B. Snader Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6, 1947, to Jan 30 1948 and that I last saw h[illegible] alive on Jan. 30 1948.

	DURATION
Immediate cause of death: Myocardial degeneration	10 mos
Due to: arterio sclerosis	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Keese Wilkens M. D. or other

Address: Westminster Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00339

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-48-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years, 4 months, 23 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 46 years, 4 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Lisbon

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Mary Emma Emma Mary Fisher

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): February 20, 1865

8. AGE: Years	Months	Days	If less than one day
82	11	6	... hrs. ... min.

9. Birthplace: Lisbon, Howard County, Maryland (Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business

FATHER 12. Name: Joshua Fisher

13. Birthplace: Howard County, Maryland

MOTHER 14. Maiden name: Elizabeth Warfield

15. Birthplace: Howard County, Maryland

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 28, 1948 (month) (day) (year)

Cemetery or crematory: Lisbon Presbyterian

Location: Lisbon, Md.

18. Funeral director: C. Harry Heer

Address: Sykesville Md.

19. Jan. 26 1948 C. Harry Heer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26, 1948, at 12.25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942, to January 25, 1948 and that I last saw her alive on January 25, 1948

	DURATION
Immediate cause of death: Cerebral hemorrhage	2 hours
Due to: arteriosclerosis about	5 years
Due to:	
Other conditions: Schizophrenia, paranoid type	49 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Irene Hohenemser, M.D. (M. D. or other)

Address: Springfield State Hospital Date signed: 1-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00340

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Berrett

(If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Berrett

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Addie Gist

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George W. Gist

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~22~~ April 25, 1858

8. AGE: Years	Months	Days	If less than one day
89	8	8	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Perry Skidmore

13. Birthplace Maryland

MOTHER 14. Maiden name Katura Parrish

15. Birthplace Maryland

16. Informant Mrs. Grace Shipley

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1948 (month) (day) (year)

Cemetery or crematory Springfield

Location Sykesville, Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Jan 3 1948 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2nd 1948, 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Jan 2, 1948 and that I last saw h[illegible] alive on Jan 2nd 1948.

Immediate cause of death	DURATION
Cardiovascular dis	7
Due to Senility & age	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date at

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Date signed 1/2/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00341

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years, 3 months

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 27 years, 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Ella Grose

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2, 1859

8. AGE: Years	Months	Days	If less than one day
88	9	19	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER — 12. Name: Nathan Van Sant

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Hannah Lee

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 1948 (month) (day) (year)

Cemetery or crematory: Springfield

Location: Sykesville Md.

18. Funeral director: Harry Kerr

Address: Sykesville Md.

19. Jan. 21 19 48 (Date rec'd by registrar) Harry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21, 1948 at 5.35a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to January 20 1948 and that I last saw her alive on January 20, 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	about 1 year
Due to generalized arteriosclerosis	about 6 years
Due to	
Other conditions Psychosis with mental deficiency	probably life long

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Nature of injury: Injured at work?

23. SIGNATURE: Irene H Kleinman M.D

Address: Springfield State Hospital M. D. or other

Date signed: 1-21-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

122b 00343 83

Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Rural --- Winfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural -- Winfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Woodbine
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: AMANDA JANE HAINES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Levi T. Haines
6.(c) If alive, give age: 82 years
7. Birth date of deceased (mo., day, yr.): Aug. 31, 1867

8. AGE: Years	Months	Days	If less than one day
80	4	8	....hrs. ....min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Cornelius Jenkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary J. Farver
15. Birthplace: Maryland

16. Informant: Levi T. Haines
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1-12-48 (month) (day) (year)
Cemetery ~~or crematory~~: Bethel Church of God
Location: near Winfield, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Jan 11 (Date rec'd by registrar) 19 48 Edna M. Hewett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9, 1948 at 6 A; M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46, to January 9, 19 48 and that I last saw her alive on January 8, 1948

Immediate cause of death	DURATION
Toxemia	6 mo.
Due to: Partial intestinal obstruction	3 yrs
Post operative adhesions	?yrs
Due to:	
Other conditions: Secondary anemia	6 mo.
Advanced arterio-sclerosis	? yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt. Airy, Md. Date signed: 1/10/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00343

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 71

1. PLACE OF DEATH:
County Carroll
City or town Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Ruth Haines

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Edward L. Haines
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1867

8. AGE: Years 80 | Months 10 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Stambaugh
13. Birthplace md

MOTHER
14. Maiden name Jemima Warfield
15. Birthplace md

16. Informant Thurston E. Haines
Address Westminster, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Jan 31, 1948 (month) (day) (year)
Cemetery or crematory Church of God
Location Uniontown Md.

18. Funeral director C. L. Bricker Son
Address Taneytown Md.

19. Jan 28 1948 Margaret R. Englar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948 at 9:01A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death Chronic Myocarditis c
acute decompensation

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Moore Deputy Medical Examiner
M. D. or other
Address Westminster Md Date signed 1-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00344

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 22 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryto

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 547 Barre Street (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Bessie Hall (Stevenson)

3.(b) Social Security Number: 212-20-5998

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1922

8. AGE: Years	Months	Days	If less than one day
25.	9	25	hrs. min.

9. Birthplace: Gasdonia, N. Carolina (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:
FATHER — 12. Name: Fredi Hall Robinson
13. Birthplace: South Carolina
MOTHER — 14. Maiden name: Ophelia Robinson
15. Birthplace: Clover S. Carolina
16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/18/48 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: A. A. County, Md.
18. Funeral director: Leith L. Brown & Sons
Address: 108 W. Montgomery St.

19. Jan. 15 1948 (Date rec'd by registrar) Albert R. [illegible] Registrar
Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1948 at 11:22 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24 1947 to Jan. 15 1948 and that I last saw her alive on January 15 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1947
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Rubert W. Evans, M. D. M. D. or other
Address: Henryton, Maryland Date signed: 1/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00345

46 ✓

Reg. Diat. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Barkhill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 23½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alverta Harner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1869

8. AGE: Years	Months	Days	If less than one day
78	1	5	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Samuel Harner

13. Birthplace Maryland

MOTHER 14. Maiden name Alice Bishop

15. Birthplace Maryland

16. Informant Mrs. Samuel Bishop

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1948 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Taneytown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

Jan 30 19 48 (Date rec'd by registrar) Leola J. Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1948, at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1947, to Jan 28 1948

and that I last saw h alive on Jan 26 1948

Immediate cause of death	DURATION
Carcinoma (stomach)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D. or other

Address Union Bridge Date signed 1-30-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00346

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 6 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1314 W. Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Clarence Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1900

8. AGE: Years	Months	Days	If less than one day
47	8	12	hrs. min.

9. Birthplace Charles City, Virginia
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Robert Harris

13. Birthplace Charles City, Virginia

MOTHER 14. Maiden name Clara Whirley

15. Birthplace Charles City, Virginia

16. Informant Cousin -John Whirley

Address 1314 W. Mulberry St. Baltimore

17. BURIAL (Burial, cremation, or removal, Which?) Date thereof 1/25/48 (month) (day) (year)

Cemetery or crematory

Location Charles City Co. Va

18. Funeral director CHAS. R. LEAKY

Address 502 MADISON AVE.

19. Jan. 21 1948 (Date rec'd by registrar) Albert R. Brandhagen Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 19 48 at 10:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 19 47 to Jan. 21 19 48 and that I last saw h... im alive on January 21 19 48

Immediate cause of death Pulmonary Tuberculosis — DURATION: Dec. 1940

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 1/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00347

97

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 17 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or Institution? 9 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street ~~X~~ Edmondson Ave. & Nunnery Lane (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hayden, Charles Swett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2/3/70

8. AGE: Years	Months	Days	If less than one day
77	11	5	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation retired lawyer

11. Industry or business

FATHER 12. Name Charles R. Hayden

13. Birthplace Maine

MOTHER 14. Maiden name Anna Bordman

15. Birthplace Canada

16. Informant Records of Springfield State Hospital

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-10-48 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Balto. Md.

18. Funeral director Williams Cook, Inc.

Address 1217 St Paul St.

19. Jan 8 1948 (Date rec'd by registrar) C. Henry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948 at 7:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947 to Jan. 8 1948 and that I last saw him alive on January 8 1948

Immediate cause of death	DURATION
Arteriosclerosis	?
Due to	
Due to	
Other conditions Senile psychosis	about 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Gross, M.D.

Martin Gross, M. D. M. D. or other

Address Sykesville, Maryland Date signed 1/8/48

00348

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Carroll
City or town: Rural --Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural --Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Howard McClain Horton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret A. Horton
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1864

8. AGE:

Years	Months	Days	If less than one day
82	5	8	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: retired

FATHER
12. Name: Ira Horton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Harriett Frizzell
15. Birthplace: Maryland

16. Informant: Mr. Carvel Horton
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-26-48 (month) (day) (year)
Cemetery or crematory: Deer Park
Location: Smallwood, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Jan 26 1948 (Date rec'd by registrar) E. M. Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1948 at 5:50 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 9 1947 to January 23 1948 and that I last saw h--- alive on January 18 1948

Immediate cause of death: Acute Cardiac Decompensation — DURATION —
Due to: Arteriosclerotic C-V disease —
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Round M. D.
M. D. or other
Address: Westminster Md. Date signed 1/28/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00349

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 10 month 7 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 649 Dover Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Paul Willis Houpe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 1, 1927

8. AGE: Years	Months	Days	If less than one day
20	2	29	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Shipping Clerk

11. Industry or business:

FATHER
12. Name: Richard Houpe
13. Birthplace: Statesville, N.Carolina

MOTHER
14. Maiden name: Bell Tatum
15. Birthplace: Georgia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 5 48 (month) (day) (year)
Cemetery or crematory: Mount Calvary
Location: Butler, Md.

18. Funeral director: Mrs K. R. Williams
Address: 322 N. Schroeder St

19. Jan. 30 (Date rec'd by registrar) 19 48 Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: January 30 19 48 at 3:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 19 45 to Jan. 30 19 48 and that I last saw him alive on January 30 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 31 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Hyman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 1/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

00350

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 8C

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John T. Johns

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife: Catherine M. Johns

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 6 1867

8. AGE: Years: 80 | Months: 7 | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pleasant Valley, Virginia (Town, county, and state)

10. Usual occupation: Teacher and County Surveyor

11. Industry or business

FATHER — 12. Name: John Johns

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Mary McDonald

MOTHER — 15. Birthplace: Virginia

16. Informant: Mrs. Catherine Johns

Address: New Windsor, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 10-48 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: H. H. Hartsler & Sons

Address: Union Bridge, Md or New Windsor, Md

19. Jany 8 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 1948, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage	
Due to: (b) Arteriosclerosis	
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 1-8-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00351

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 4 mons. 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatoruim
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town (P.O. Delmar, Del.)
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.R. #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: DAISY MAE JOHNSON

3.(b) Social Security Number: 213-22-7033

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 23, 1926

8. AGE: Years	Months	Days	If less than one day
21	9	16	..... hrs. ..... min.

9. Birthplace Wilmington, Del.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Frank Johnson
13. Birthplace Maryland

MOTHER
14. Maiden name Floria David
15. Birthplace Maryland

16. Informant Deceased
Address

17. B.
(Burial, cremation, or removal. Which?)
Date thereof 1-13-48
(month) (day) (year)

Cemetery or crematory Union
Location Wicomico

18. Funeral director James F. Stewart
Address Salisbury Md

19. January 9 19 48
(Date rec'd by registrar)
Allen R. Longbotham Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 19 48, at 4:A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30, 1946, to January 9, 1948, and that I last saw her alive on January 9, 1948.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben D. Truax, M.D.
M. D. or other
Address Henryton, Maryland Date signed 1-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 00352

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mons. 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore, 31
(If outside city or town limits, write RURAL and give nearest town)
Street No. 238 Dallas Court
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Marshall Irvin Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 13, 1933

8. AGE: Years	Months	Days	If less than one day
14	3	4	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business:

FATHER
12. Name: Charles Jones
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Beulah Reddick
15. Birthplace: Virginia

16. Informant: Mother- Beulah Jones
Address: 238 Dallas Ct., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-21-48 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A.A. County, Md.
18. Funeral director: Chas. Hooper
Address: 510-12 N. Carrollton Ave.

19. Jan, 17, 48 (Date rec'd by registrar) Albert R. Frankhouser Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17, 1948, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24, 1947, to January 17, 1948 and that I last saw him alive on January 17, 1948

Immediate cause of death	DURATION
Bone Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dallas H. Bynum, M. D. (M. D. or other)
Address: Henryton, Md. Date signed: 1-17-48


RECEIVED
JAN 30 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108

Reg. Diat. No. 87353

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Route 1

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Perry Thomas Jones

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Married

6.(b) Name of husband or wife: Mamie Jones

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug 8 - 1882

8. AGE:

Years	Months	Days	If less than one day
65	4	8	____ hrs. ____ min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Abram Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ethelene Jones
15. Birthplace: Maryland

16. Informant: Mamie Jones
Address: Union Bridge, Md. Rt 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20, 1948 (month) (day) (year)

Cemetery or crematory: Mt Joy Cemetery

Location: Uniontown, Md.

18. Funeral director: W. A. Hartsell Sons

Address: Union Bridge, Md.

19. Jan 20, 1948 Leslie D. Repp
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 1948 at 9:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1948, to Jan 16 1948 and that I last saw him alive on Jan 16 1948

Immediate cause of death	DURATION
Cardiac Degeneration	
Due to Pneumonia Lobar	3 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 1-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00354

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: 314 Maryland Avenue, Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: JOSEPH E. KINSER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	DIVORCED

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10/29/04

8. AGE: Years	Months	Days	If less than one day
43	2	6	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Spinner

11. Industry or business

FATHER 12. Name: Sam Kinser

13. Birthplace: West Virginia

MOTHER 14. Maiden name: Virginia McElfish

15. Birthplace: West Virginia

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-8-48 (month) (day) (year)

Cemetery or crematory: Cumberland

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Jan. 5 19 48 C. Harvey Wilson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 19 48 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 31 19 47 to January 5 19 48 and that I last saw h... im alive on January 5 19 48

Immediate cause of death	DURATION
Bronchopneumonia O.K.	2 days
Due to:	
Due to:	
Other conditions: Syphilis & Syphilitic meningo-encephalitis (Include pregnancy within 3 months of death)	1 yr

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 1/5/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00355

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Covers Corner

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Covers Corner

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural--New Windsor

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CARRIE ELIZABETH KOONTZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Harry Koontz

6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): March 29, 1866

8. AGE:

Years	Months	Days	If less than one day
81	10	0	...hrs. ...min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER

12. Name: Andrew Alexander

13. Birthplace: Maryland

MOTHER

14. Maiden name: Olevia A. Cassell

15. Birthplace: Maryland

16. Informant: Miss Myrle Koontz

Address: New Windsor, Md.

17. (Burial, ~~cremation, or removal. Which?~~) Burial Date thereof: 2-1-48 (month) (day) (year)

Cemetery ~~or crematory~~: Linganore

Location: Unionville, Frederick Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. (Date rec'd by registrar) 1-31-1948 E. M. Farmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29th 1948 at 6:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1947 to Jan 25th 1948 and that I last saw him alive on Jan 25th 1948

	DURATION
Immediate cause of death: Chronic Diabetes Mellitus Gangrene	
Due to:	
Due to:	
Other conditions: Abdominal Tumor possibly Cancerous	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: L. C. Leitch, M.D.

Address: New Windsor M. D. or Other

Date signed: 1-29-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00356

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:
Hewitt Nursing Home

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Armina B. Ledbetter

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William Ledbetter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 15, 1858

8. AGE: Years	Months	Days	If less than one day
89	2	26	..... hrs. ..... min.

9. Birthplace: Covington, Ohio
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: William Giffin
13. Birthplace: Ohio

MOTHER
14. Maiden name: Cynthia Reddick
15. Birthplace: Ohio

16. Informant: William Medford

Address: Baltimore, Md

17. cremation (Burial, cremation, or removal. Which?) Date thereof 1/10/48 (month) (day) (year)

Cemetery or crematory: Loudon Park Crematory

Location: Baltimore, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. Jan 10 1948 (Date rec'd by registrar) Edna M Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1948 at 12½a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23 1947 to Jan 10 1948 and that I last saw h.r alive on Jan 9 1948 19....

Immediate cause of death	DURATION
senility	
Due to chr. myocarditis	
chr. arteriosclerosis	
Due to chr. interstitial nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Lawson M.D.
M. D. or other

Address: Taylorsville Date signed 1/10/48

00357

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 15 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? Sykesville, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick (If outside city or town limits, write RURAL and give nearest town)
Street No. 23 Hamilton Avenue (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FLORETTA SOPHIE LEE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Lewis W. Lee
6.(c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): 12/19/1884

8. AGE: Years	Months	Days	If less than one day
63	1	9	....hrs. ....min.

9. Birthplace: Frederick County (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Ezra L. Kemp
13. Birthplace: Frederick

MOTHER
14. Maiden name: Florence Ramsburg
15. Birthplace: Frederick

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-28-48 (month) (day) (year)
Cemetery or crematory:
Location: Frederick, Md.
18. Funeral director: M. R. Eichelberger & Son
Address: Frederick, Md.

19. Jan. 28 1948 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1948 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13 1947 to January 28 1948 and that I last saw her alive on January 27, 1948

	DURATION
Immediate cause of death: Diabetes mellitus	10 yrs.
Due to: Generalized arteriosclerosis	10 yrs.
Due to: Gangrene of left foot	2 wks.
Due to: diabetes & arteriosclerosis	
Other conditions: Senile Psychosis, simple deterioration	8 or 9 years

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.: ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of: ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall M.D. M. D. or other
Address: Sykesville, Maryland Date signed: 1/28/48


RECEIVED
JAN 29 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

pc 00358

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 2 months, 1 day

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 years, 2 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Gertrude Breckemridge Lee alias - Curnett Adams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 4, 1876

8. AGE: Years	Months	Days	If less than one day
71	3	27	hrs. min.

9. Birthplace: Pasadena California
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: Theodore Adams
13. Birthplace: unknown

MOTHER
14. Maiden name: Catherine Sciken
15. Birthplace: unknown

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-3-48 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Henry Ecker

Address: Sykesville, Md.

19. Feb. 3 1948 C. Henry Ecker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1948 at 4.15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Janaury 26, 1944, to January 30, 1948 and that I last saw her alive on January 30, 1948

Immediate cause of death	DURATION
Pulmonary embolism	few minutes
Due to: ~~xxx~~ Chronic myocarditis and myocardial degeneration	about 4 years
Due to: generalized arteriosclerosis	5 years
Other conditions: senile psychosis, paranoid type	more than 4 years

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Irene Hitchmen, M.D.

Springfield State Hospital M. D. or other

Address: Date signed 1-31-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b

00359

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 month 16 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 311 Calhoun Street
(If rural, give LOCATION)
(a) If veteran, name war: V

3. (a) FULL NAME: Grace Washington Lee

3. (b) Social Security Number: 217-22-7725

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	married

6.(b) Name of husband or wife: Robert E. Lee
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): August 13, 1912

8. AGE: Years	Months	Days	If less than one day
35	4	26	..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Albert Richard Washington
13. Birthplace: Virginia

MOTHER
14. Maiden name: Grace Armstrong
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Jan 12, 1948
Cemetery or crematory: Mt Auburn Cemetery
Location: Baltimore, Md.

18. Funeral director: Charles R Lane
Address: 802 Madison Ave

19. (Date rec'd by registrar) Jan. 8 19 48 Albert R. Swandyke Registrar
Local Deputy

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: January 8 19 48 at 4:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 47 to Jan. 8 19 48 and that I last saw her alive on January 8 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Offman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 1/8/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83

00360

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year.

Hospital, Institution, or street address where death occurred: Prep Cum

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Prep Cum

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clayton John Leese

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Helen M. Leese

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	2	2		

9. Birthplace: Silver Run - Carroll Co. Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Albert David Leese

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lucinda Palmer

15. Birthplace: Maryland

16. Informant: Mrs. Helen M. Leese

Address: Westminster County 3 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 18 1948 (month) (day) (year)

Cemetery or crematory: St. Davids Ghurmans

Location: Hanover, Pa. R.D.

18. Funeral director: H. A. Frealy

Address: Hanover, Pa.

19. Jan. 16 1948 Md. W.P.S. Denner (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1948 at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 1-15-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00361

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3-9-yrs

Hospital, institution, or street address where death occurred:
96 E. Green St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 E. Green
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: John Casher Leffert

3.(b) Social Security Number: 3mo

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Lillie Ward

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): April 12 - 1888

8. AGE: Years	Months	Days	If less than one day
59	9	1	...hrs. ...min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: John Leffert
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Seipp
15. Birthplace: Carroll Co. Md.

16. Informant: Naval Leffert
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 16 1948 (month) (day) (year)
Cemetery or crematory: Baldwin Cemetery
Location: Westminster, Md.

18. Funeral director: H. Barnhart & Son
Address: Westminster, Md.

19. 1/15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1948, at 9. A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to Jan 13, 1948
and that I last saw him alive on Jan. 12, 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	32 hrs
Due to: arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

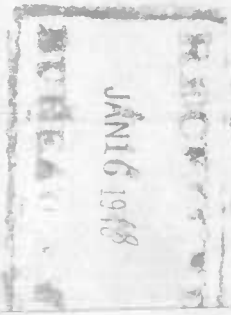
Means of injury: Injured at work?

23. SIGNATURE: C. Reese Wilkens M. D. or other
Address: Westminster Date signed: 1/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00362

83a

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Almost 3 weeks

Hospital, Institution, or street address where death occurred:
62 Liberty St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Clara Mitten Loane

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Edwin D. Loane, Jr.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 28, 1865

8. AGE:

Years	Months	Days	If less than one day
82	4	11	..... hrs. ..... min.

9. Birthplace: Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: John H. Mitten
13. Birthplace: Westminster, Md.

MOTHER
14. Maiden name: Elizabeth Slade
15. Birthplace: Westminster Md.

16. Informant: J. Albert Mitten
Address: 62 Liberty St. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/48 (month) (day) (year)

Cemetery or crematory: Prides Cemetery

Location: Near Westminster, Md.

18. Funeral director: J. E. Myers Jr.

Address: Westminster Md.

19. 1/8 (Date rec'd by registrar) L. K. Unverzagt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7th 1948, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31st 1947, to Jan. 7th 1948 and that I last saw h.e.r. alive on Jan. 7th 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Vascular Kidneys	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. H. Billingslea, M.D.
M. D. or other

Address: Westminster, Md. Date signed 1-8-48

Every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00363

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 20 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 month, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 407 Washington Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME
ELIZABETH LOWRY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Peter J. Lowry (deceased)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10/15/68

8. AGE: Years	Months	Days	If less than one day
79	3	7	..... hrs. ..... min.

9. Birthplace: Belfast, Ireland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Thomas Surgin
13. Birthplace: Belfast; Ireland

MOTHER
14. Maiden name: Mary Freeland
15. Birthplace: Belfast, Ireland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 1-26-48 (month) (day) (year)

Cemetery or crematory: Tarrytown

Location: Tarrytown, New York

18. Funeral director: C. Harry Weed

Address: Sykesville, Md.

19. Jan 22 1948 C. Harry Weed
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 19 48, at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 19 47 to January 22 19 48 and that I last saw her alive on January 21 19 48

Immediate cause of death	DURATION
Chronic Myocarditis and Myocardial Degeneration	Known 12-2-47
Due to:	
Due to:	
Other conditions: Arteriosclerosis with Cardio-Vascular Renal Disease	More than 5 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. Virginia Berger M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 1/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00364

Reg. Diat. No. 74

1. PLACE OF DEATH

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 7 mo 16 da

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Isabelle Martocci

3.(b) Social Security Number: None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Pasquale Martocci

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 29-1878

8. AGE: Years 69 Months 8 Days 27 If less than one day: hrs. min.

9. Birthplace: Rochester N.Y.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Felice, Paduta
13. Birthplace: Italy

MOTHER
14. Maiden name: Antonnette —
15. Birthplace: Italy

16. Informant: Gilbert, Martocci
Address: 3114 Abel Ave Balto

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 1 28 48 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Old Frederick Rd

18. Funeral director: The Dissel Bro.

Address: 1800 E. Lombard St.

19. (Date rec'd by registrar) 1/26/48 19 C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25th 1948 at 3-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9th 1945 to Jan 25th 1948 and that I last saw h.. alive on Jan 25th 1948

Immediate cause of death: Cerebral Hemorrhage — DURATION 2 da.

Due to: Arteriosclerosis — 5 yrs.

Due to: Hypertension — 5 yrs.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Hastings M.D. M. D. or other

Address: Sykesville Date signed: 1/25/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 00365

CERTIFICATE OF DEATH

Reg. Diat. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: County Carroll; City or town Union Bridge (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? Life; Hospital, institution, or street address where death occurred:; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Md. County Carroll; City or town Union Bridge (If outside city or town limits, write RURAL and give nearest town); Street No. (If rural, give LOCATION); 2.(a) If veteran, name war

3.(a) FULL NAME ~~Baby Boy Mellon~~ Sterling McCauley (Sterling McCauley)

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	D

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1948	Jan	3d	17 hrs. ..... min.

9. Birthplace Union Bridge Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Sterling McCauley

13. Birthplace Carroll Co Md

MOTHER 14. Maiden name Charlotte Buffington

15. Birthplace Carroll Co

18. Informant Charlotte Buffington

Address Union Bridge Md

17. (Burial, cremation, or removal. Which?) Date thereof Beaver Dam (month) (day) (year) 1-3-48

Cemetery or crematory Beaver Dam

Location Near Union Bridge Md

16. Funeral director Raymond K Wright

Address Union Bridge Md

19. Jan 3 1948 (Date rec'd by Registrar) Leslie D. Fidler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1948 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to Jan 3 1948 and that I last saw him alive on Jan 2 1948

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D. V. Hess M. D. or other

Address Union Bridge Date signed 1-3-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 00366

Reg. Diat. No. 77

1. PLACE OF DEATH:

County Carroll

City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carrie J. Miller

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife Lloyd H. Miller

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) August 30, 1887

8. AGE: Years	Months	Days	If less than one day
60	4	22	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Hwf.

11. Industry or business

FATHER
12. Name Nelson W. Garrett
13. Birthplace Maryland

MOTHER
14. Maiden name Matilda Resh
15. Birthplace Maryland

16. Informant Lloyd H. Miller

Address Hampstead, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 24 1948 (month) (day) (year)

Cemetery or crematory Hampstead

Location Carroll Co., Maryland

18. Funeral director Edw. C. Tipton

Address Hampstead, Maryland

19. Jan 23 1948 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948 at 12:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 1948 to Jan. 21 1948 and that I last saw her alive on Jan. 20 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to Hypertension and Cardio-Vascular Disease	15 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice C. Porterfield M. D. or other

Address Hampstead, Md Date signed 1-22 48

VS. A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 L   BC 00367
Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 month 28 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland   County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 400 N. Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: Arthur Moore
3. (b) Social Security Number: 218-09-2504

4. Sex: male
5. Color or race: col
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Marion Moore
6.(c) If alive, give age: 44 years
7. Birth date of deceased (mo., day, yr.): September 15, 1894

8. AGE: Years 53 Months 4 Days 9 If less than one day ... hrs. ... min.

9. Birthplace: Eastern Shore, Virginia (Town, county, and state)
10. Usual occupation: Plumber Helper
11. Industry or business:
FATHER 12. Name: Henry Moore
13. Birthplace: Virginia
MOTHER 14. Maiden name: Emily Scarter
15. Birthplace: Virginia
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/48 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location:
18. Funeral director: Mrs Katie R. Williams
Address: 322 N. Schroeder St.
19. Jan. 24, 1948 (Date rec'd by registrar) Albert R. Swanthan [signature] Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24, 1948, at 12 A.M. Noon
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1947, to Jan. 24, 1948
and that I last saw him alive on January 24, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1947
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Maryland   Date signed: 1/24/48

VS A15   9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00368

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Gamber
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Gamber
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural --Finksburg
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JESSE W. MYERS

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Annie L. Myers
6.(c) If alive, give age: 76 years
7. Birth date of deceased (mo., day, yr.): May 29, 1867

8. AGE:

Years	Months	Days	If less than one day
80	7	18	...hrs. ...min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Lewis A. Myers
13. Birthplace: Maryland

MOTHER
14. Maiden name: Louise Bair
15. Birthplace: Maryland

16. Informant: Mrs. Annie L. Myers
Address: Finksburg, Maryland

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 1-19-48 (month) (day) (year)
Cemetery ~~or crematory~~: Deer Park
Location: Smallwood, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 1/20 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17, 19 48, at 12;17A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19..., to Jan 17 19 48.
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Carcinoma of Prostate	
Renal Cardiovascular disease	
~~Due to~~ with myocarditis and	
myocardial insufficiency	
Due to senile changes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. H. Lawson M.D. (M. D. or other)
Address: Sykesville Date signed 1/17/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00369

52

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Springfield State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 2 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? August 8, 1947-Jan. 10, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town ?
(If outside city or town limits, write RURAL and give nearest town)

Street No. ?
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Sarah Sementha Nichols

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 1865 ?

8. AGE: Years	Months	Days	If less than one day
78			... hrs. ... min.

9. Birthplace Montgomery County
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Hanson Brown
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Springfield State Hospital records
Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-13-48 (month) (day) (year)

Cemetery or crematory Woodside

Location Brinkleys Md

18. Funeral director Raymon Bowers

Address Laytonsville Md

19. Jan. 10 1948 (Date rec'd by registrar) C Nancy Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8 1947 to January 10 1948

and that I last saw her alive on Jan. 8, 1948

Immediate cause of death	DURATION
Cancer of bladder	2 wks (known)
Due to	
Due to	
Other conditions Senile psychoses	? 6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

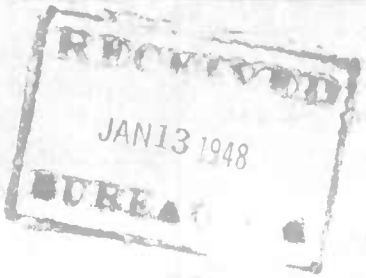
23. SIGNATURE Joseph H. Marshall, M.D.
M. D. or other

Address Springfield State Hospital Date signed 1/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


JAN13 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00370

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years, 11 months, 1 day
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 14 years, 11 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard Co.
City or town: Ilchester (If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice O'Donnell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-18-1874

8. AGE: Years	Months	Days	If less than one day
73	8	23	hrs. min.

9. Birthplace: Montgomery County, Maryland (Town, county, and state)
10. Usual occupation: teacher
11. Industry or business

FATHER
12. Name: James O'Donnell
13. Birthplace: Montgomery County, Maryland

MOTHER
14. Maiden name: Mary C. Ray
15. Birthplace: Montgomery County, Maryland

16. Informant: Hospital records
Address: Sprignfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 14 1948 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: Baltimore, Md.
18. Funeral director: Easton Ford
Address: Ellicott City, Md.
19. Jan 11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1948, at 5.45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to January 10, 1948 and that I last saw her alive on January 10, 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	about 10 years
Due to: generalized arteriosclerosis	13 years
Due to:	
Other conditions: Manic depressive psychosis, depressed type	about 15 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hotchman M.D
M. D. or other
Address: Springfield State Hospital
Date signed: 1-11-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

00371

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, Institution, or street address where death occurred:
R. D. 6
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. D. 6
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha Ellen Owings

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife George Monroe Owings
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 31 - 1870

8. AGE: Years 77 | Months 7 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name George W. Cobles
13. Birthplace Carroll Co. Md

MOTHER
14. Maiden name Emily Jane Brown
15. Birthplace Carroll Co. Md.

16. Informant Mrs. Lois V. Owings
Address Westminster R.D. 6. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17-1948 (month) (day) (year)
Cemetery or crematory Deer Park Cemetery
Location Smallwood, Md.

18. Funeral director H. Bankard
Address Westminster, Md.

19. 1/16 (Date rec'd by registrar) 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1948, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-12 1948, to 1-15 1948
and that I last saw h... alive on 1-14 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Senility	
Due to	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Billingslea, M.D.
M. D. or other
Address Westminster, Md. Date signed 1-14-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 00372

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: THERESA EVA PAJKIN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Joseph Pajkin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 9, 1872

8. AGE: Years	Months	Days	If less than one day
75	3	22	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Hill

FATHER — 13. Birthplace: Prague, Czechoslavakia

MOTHER — 14. Maiden name: Mary Kobsky

MOTHER — 15. Birthplace: Prague, Czechoslavakia

16. Informant: Gustave League

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4, 1948 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Eastern Avenue

18. Funeral director: Libby & Zickefoose Inc.

Address: 403 W. Lafayette St.

19. Jan. 31, 19 48 (Date rec'd by registrar) Albert R. Swanhorn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31, 1948, to Jan. 31, 1948 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Arteriosclerotic heart disease	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W. Fowler, M. D. M. D. or other

Address: Henryton, Md. Date signed: 1-31-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 00373

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural, Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr, 8 mo, 4 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital, Sykesville, Md.

How long in hospital or institution? 1 yr, 8 mo, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No. 246 East Seventh Street
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: PEDDICORD, James Walter

3.(b) Social Security Number: 214-10-2452

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Cora Peddicord

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 5-22-95

8. AGE: Years	Months	Days	If less than one day
52	7	25	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ——

FATHER
12. Name: William Luther Peddicord
13. Birthplace: Thurmont

MOTHER
14. Maiden name: Mary Ellen Wolfe
15. Birthplace: Foxville, Md

16. Informant: Records of Springfield State Hosp.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-20-1948 (month) (day) (year)

Cemetery or crematory: Union Chapel Cemetery

Location: Near Walkersville - Md.

18. Funeral director: C. E. Cline & Son

Address: Frederick - Md.

19. Jan 17 1948 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17 1948 at 9.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947, to January 17 1948 and that I last saw him alive on January 16 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to: Syphilis?	?
Due to:	
Other conditions: Psychosis with mental deficiency	more than 4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —— Date of op.

Autopsy results: ——

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ——

Accident, suicide, or homicide: —— Date of

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work? ——

23. SIGNATURE: Martin Gross, M.D. M. D. or other

Address: Sykesville, Md. Date signed 1-17-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00374

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs 10 mos 21 da
Hospital, Institution, or street address (where death occurred): Springfield State Hospital
How long in hospital or institution? 26 yrs 10 mos 21 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Margaret Ellen Richards

3.(b) Social Security Number

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 30th - 1883

8. AGE: Years 63 | Months 9 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business at home

FATHER
12. Name Jacob J. Miller
13. Birthplace Md.

MOTHER
14. Maiden name Jane Cilly
15. Birthplace Ireland

16. Informant Clyde Richards husband
Address 25 Rainy St Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2 1948 (month) (day) (year)
Cemetery or crematory Greenway Cem.
Location Berkeley Springs, W. Va.
18. Funeral director C. L. Hunter
Address Berkeley Springs, W. Va.

19. Jan. 30 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1948 at 9-15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3d 1921 to Jan 30 1948 and that I last saw h... alive on Jan 30 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 da
Due to	
Sml Arteri Sclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE W. J. Gaston M. D. M. D. or other
Address Sykesville Md Date signed 1/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

00375 8d

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Broad Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clyde Franklin Ricketts

3. (b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Julia M Ricketts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 30 - 1905

8. AGE: Years	Months	Days	If less than one day
42	4	3	..... hrs. ..... min.

9. Birthplace Cumberland, Maryland (Town, county, and state)

10. Usual occupation Painter by trade

11. Industry or business

FATHER

12. Name Charles Edward Ricketts

13. Birthplace Maryland

MOTHER

14. Maiden name Franklin E Fritz

15. Birthplace Maryland

16. Informant Mrs Julia M Ricketts

Address Taneytown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4-1948 (month) (day) (year)

Cemetery or crematory Trinity Cemetery

Location Union Bridge Road

18. Funeral director D D Hartsler & Sons

Address Union Bridge & New Windsor Md

19. Jan 3 1948 (Date rec'd by registrar) Ernest N Bird Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1948 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2 1948, to Jan. 2 1948 and that I last saw him alive on Jan. 2 1948

Immediate cause of death	DURATION
Coronary Artery Disease	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None done Date of op.

Autopsy results Not Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. S. McVaugh M.D. Acting Deputy Medical Examiner

Address Taneytown, Md. Date signed Jan. 2, 1948

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

922 00376

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
Carroll County Home
How long in hospital or institution? 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Carroll County Home
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Andrew Milton Routzohn

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, 1874

8. AGE: Years	Months	Days	If less than one day
73	7	3	hrs. min.

9. Birthplace: near Westminster, Md. (Town, county, and state)
10. Usual occupation: farm labor
11. Industry or business:
FATHER 12. Name: Ezra Routzohn
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah Petry
15. Birthplace: Maryland
16. Informant: Mrs. James Brothers
Address: New Windsor, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof 1/30/48 (month) (day) (year)
Cemetery or crematory: Meadow Branch Cemetery
Location: near Westminster, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 1/29 (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 19 48 at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to 1-28- 19 48
and that I last saw h... alive on 1-26-48 19...

	DURATION
Immediate cause of death: Ediac decompensation	Progressive (2 years)
Due to: Valvular lesions	many years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W. C. Reese M. D. or other
Address: Westminster, Md. Date signed 1-28-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13B BE 00377

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months 10 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 811 N. Dallas Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: George Thomas Saunders

3.(b) Social Security Number: 217-18-618

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): September 14, 1902

8. AGE: Years	Months	Days	If less than one day
45	3	11	... hrs. ... min.

9. Birthplace: Goldsburg, N. Carolina
(Town, county, and state)

10. Usual occupation: Skill Laborer

11. Industry or business

FATHER
12. Name: Thomas Ashley Saunders
13. Birthplace: Unknown

MOTHER
14. Maiden name: Josephine Johnson
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9/1948 (month) (day) (year)
Cemetery or crematory Mt Calvary Cemetery
Location C. & A. Co. Md.
18. Funeral director Robert F. Wiseman
Address 15-16 McElderry St

19. Jan. 4, 1948 (Date rec'd by registrar) Albert R. Trundle Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1948 at 9:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 1947 to Jan. 4 1948 and that I last saw h... im alive on January 4 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	August 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Reuben D. Kuman, M. D. M. D. or other
Address Henryton, Maryland Date signed 1/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462 BC 00378

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 2 yr 11 mo 7 da

Hospital, Institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution: 2 yr 11 mo 26 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1810 E. Monument St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Margaret Schaeffer

3.(b) Social Security Number: None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: William F. Schaeffer

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov 22 1883

8. AGE: Years: 64 | Months: 1 | Days: 16 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: at home

MOTHER FATHER

12. Name: Ludwig Luh

13. Birthplace: Germany

14. Maiden name: Kunigenda Lesser

15. Birthplace: Germany

18. Informant: Mr. Calvin Schaeffer

Address: 3114 Normont Ave Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/10/48 (month) (day) (year)

Cemetery or crematory: xxxx Lorraine Cem

Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS INC

Address: North & Pa. Aves., Balto., Md.

19. 1/9 (Date rec'd by registrar) 1948 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8th 1948 at 12-15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29 1946, to Jan 8th 1948 and that I last saw h. alive on Jan 8th 1948

	DURATION
Immediate cause of death: ____	
Due to: Carcinoma Intestinal	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W. J. Martin M.D. M. D. or coroner

Address: Sykesville Md. Date signed: 1/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00379

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above piece of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Louis P. Schultz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary B. Schultz

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 6th, 1865

8. AGE: Years	Months	Days	If less than one day
82	9	1	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Louis H. Schultz

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Henrietta

15. Birthplace: Maryland

16. Informant: Miss Annie Randall

Address: Sykesville, Md.

17. Burial Jan. 9, 1948 (Burial, cremation, or removal. Which?) Date thereof 1948 (month) (day) (year)

Cemetery or crematory: Springfield

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Jan 7 1948 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 6th 1948, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1948, to Jan. 6 1948

and that I last saw him alive on Jan. 6 1948

Immediate cause of death	DURATION
Coronary thrombus	
Due to Arteriosclerosis and	
Due to Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jos. E. Martens M. D. or other

Address: Randallstown, Md. Date signed 1/7/48

is especially important. Physicians: please write the causes of death clearly and

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

[redacted] 14 FEB 11 194[illegible]

Registered No. 74

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland Carroll County.
(b) Street address Sykesville, Md.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Hull Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Junior Shaver

3 (b) If veteran, name war World War II

3 (c) Social Security Account No. 723-10-4141

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dorothy Shaver

see 2nd Certificate 6 (c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.) Jan. 30 - 1925

8. AGE: Years	Months	Days	If less than one day
22 23	11	9	hr. min.

9. Birthplace Hardtosville, Va.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Martin Shaver Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name Mollie Sprouse
15. Birthplace Va.

16 (a) Informant Dorothy Shaver
(b) Address Sykesville Md

17 (a) Burial (b) Date thereof Jan. 13-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Natl.
Location Frederick Road

18 (a) Funeral director John G. Connelly
(b) Address 411 E. Eager St Balto

19 (a) JAN 13 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1948, at 10 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease with apoplexy of the lungs as a
Due to secondary cause (1/29/48-abc)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 1-10-48

VS 151

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 00381

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 9 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RUTH GRAY STONE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Eugene Stone

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 9, 1904

8. AGE: Years	Months	Days	If less than one day
43	9	25	..... hrs. ..... min.

9. Birthplace: Urbana, Frederick Co., Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William McK. Roderick
13. Birthplace: Maryland

MOTHER
14. Maiden name: Claire Mercer
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 1948 (month) (day) (year)
Cemetery or crematory: mt Olivet
Location: Frederick maryland

18. Funeral director: M. R. Eteliism
Address: Frederick maryland

19. Jan 3. 1948 (Date rec'd by registrar) C. Harvey Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 19 48 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ------- 19..... to ..... 19.....
and that I last saw h..... alive on ------- 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Hypertensive cardio-vascular disease	
Due to:	
Other conditions: Epilepsy	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ------- Injured at work?

23. SIGNATURE: James T. Mond, Deputy Medical Examiner
M. D. or other

Address: Westminster Md. Date signed 1-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00382

CERTIFICATE OF DEATH

Reg. Dist. No. 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Myers District, Westminster, R.D.2 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No.: R. D. 2 (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha Cordelia Study

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Milton J. Study

6.(c) If alive, give age: 76 years

7. Birth data of deceased (mo., day, yr.): July 21 1874

8. AGE: Years	Months	Days	If less than one day
73	5	14	....hrs. ....min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Housewife

FATHER

12. Name: G. S. Frounfelter

13. Birthplace: Carroll County, Md.

MOTHER

14. Maiden name: Lydia Pitzer

15. Birthplace: Adams County, Pa.

16. Informant: Paul L. Study

Address: Westminster, Md. R. D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/7/48 (month) (day) (year)

Cemetery or crematory: St. Marys Union Cem. Silver Run, Md.

Location: Silver Run, Md.

18. Funeral director: J. W. Little & Son

Address: Littlestown, Pa. Per R. A. Fink

19. Jan. 6th. 1948 (Date rec'd by registrar) Calvin Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1948 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17 1947 to Jan 5 1948 and that I last saw her alive on Jan 5 1948

Immediate cause of death	DURATION
Chronic myocardial disease	5 yrs
Due to	
Due to	
Other conditions Adenoma of Thyroid	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Donald B. Cooper M. D. or other

Address: Littlestown Pa Date signed: 1-5-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00383

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month 16 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1320 Etting Street
(If rural, give LOCATION)

2(a) If veteran, name war:

3. (a) FULL NAME: William Taylor

3. (b) Social Security Number: 218-10-3787

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Lottie Taylor

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): May 25, 1897

8. AGE: Years	Months	Days	If less than one day
50	7	23	..... hrs. ..... min.

9. Birthplace: Snow Hill, N. Carolina
(Town, county, and state)

10. Usual occupation: Gas & Electric

11. Industry or business:

FATHER
12. Name: Frank Taylor
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Louise Jackson
15. Birthplace: N. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 16 1948 (month) (day) (year)
Cemetery or crematory: Arbutus Mem. Park
Location: Baltimore Co. Md.

18. Funeral director: Chas. H. Stallings & Son
Address: 1631 Druid Hill Ave.

19. Jan. 12 1948 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: January 12 1948 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from October 27 1947, to Jan. 12 1948 and that I last saw h im alive on January 12 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Nelson W. Swan M. D.
M. D. or other
Address: Henryton, Maryland Date signed: 1/12/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00384

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 5 months, 1 day
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 years, 5 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3815 Granada Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Bell Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 25, 1881

8. AGE: Years	Months	Days	If less than one day
66	4	19	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: housekeeper
11. Industry or business

FATHER
12. Name: Dave Benney
13. Birthplace: unknown

MOTHER
14. Maiden name: Minnie Johnson
15. Birthplace: Pennsylvania

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19 1948 (month) (day) (year)
Cemetery or crematory: Springfield Cemetery
Location: Sykesville Maryland
18. Funeral director: C. Harry Weir
Address: Sykesville Maryland
19. Jan 19 1948 (Date rec'd by registrar) C Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14, 1948 at 3.40 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4, 1944 to January 13, 1948 and that I last saw her alive on January 13, 1948

	DURATION
Immediate cause of death: broncho-pneumonia	3 days
Due to: hypertensive cardiovascular disease	over 4 years
Due to: emphysema	4 years
Other conditions: Paranoid condition	about 4 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hohmann, M.D. (M. D. or other)
Address: Springfield State Hospital Date signed: 1-14-48

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00385

Reg. Diat. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Greenmount (If outside city or towa limits, write RURAL and give nearest town)

How long in above place of death? 12 Yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Greenmount (If outside city or town limits, write RURAL and give nearest town)

Street No.: Hanover Pike (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ernest H. Treuth

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Legally Separated

6.(b) Name of husband or wife: Eleanora Treuth

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 19, 1883

8. AGE: Years	Months	Days	If less than one day
64	6	4	..... hrs. ..... min.

9. Birthplace: Baltimore Co., Md. (Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business

FATHER — 12. Name: Charles H. Treuth

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Keiner

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs. Elva C. Payne

Address: 610 Coleraine Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-26-48 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md.

18. Funeral director: G. Howard Strong

Address: 3207 W. North Ave.

19. Jan. 23 1948 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23, 1948 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1943, to JAN. 23 1948 and that I last saw h.. alive on January 19 1948

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to: Coronary Heart Disease	?
Due to: Chronic Myocarditis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Joseph E. Buck M.D. M. D. or other

Address: Hampstead Md. Date signed 1-23-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00386

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elias Herman Wagner

3.(b) Social Security Number 212-12-9683

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Gertrude E. Gingling
6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1896

8. AGE: Years	Months	Days	If less than one day
51	1	24	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name E. Jerome Wagner
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Carrie Haines
15. Birthplace Carroll Co. Md.
16. Informant Gertrude Wagner
Address Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 13, 1948 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster Md.
19. 1/12 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1948, at 9-15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

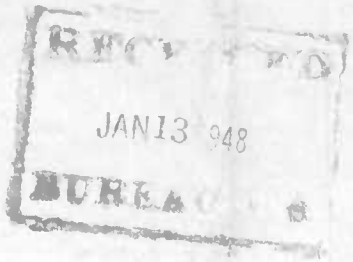
Immediate cause of death	DURATION
Coronary Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Shanks Deputy Medical Examiner
M. D. or other
Address Westminster, Md Date signed 1/12/48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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00387

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Queen Anne's

City or town: Stevensville
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME

William Henry White

3.(b) Social Security Number

218-03-3799

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 30, 1902

8. AGE: Years	Months	Days	If less than one day
45	5	11	..... hrs. ..... min.

9. Birthplace: Stevensville, Md.
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business

FATHER
12. Name: Edward White
13. Birthplace: Maryland

MOTHER
14. Maiden name: Agnes Wilson
15. Birthplace: Maryland

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/48 (month) (day) (year)

Cemetery or crematory .....

Location: Stevensville Md

18. Funeral director: Sarah L Brown Son

Address: 1084 Montgomery St

19. Jan. 10 (Date rec'd by registrar) 19 48 Albert R. Strandberg Registrar
Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 19 48 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 19 48 to Jan. 10 19 48 and that I last saw him alive on January 10 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W Lucas, M.D. M. D. or other

Address: Henryton, Maryland Date signed 1/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00388

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 5 mos 18 da

Hospital, institution, or street address (if not in hospital) where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 5 mos 18 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State Md. Country

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Mabel Strawbridge Williams

3.(b) Social Security Number

4. Sex F

5. Color or race W.

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Frank Starr Williams

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 30 - 1877

8. AGE: Years 76 | Months 11 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation housework

11. Industry or business at home

FATHER 12. Name John S Mackey

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Moffitt

15. Birthplace Carroll Co Md.

16. Informant Frank S Williams Jr 1233 North 46th St Philadelphia

17. Disposition Cremation Date thereof 1-7-48 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory London Park

Location Balto Md.

18. Funeral director Louis Byers

Address 5005 Pk Heights Ave

19. ... 19... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4th 1948 at 6-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1945 to Jan 4th 1948 and that I last saw her alive on Jan 4th - 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 da
Due to Arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE W J Gaston M.D. M. D. or other

Address Sykesville Md. Date signed 1-6-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00389

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 9 months, 27 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 years, 9 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Whiteford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: PRICE W. WILLIAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11/18/1894

8. AGE: Years	Months	Days	If less than one day
53 y	1	17	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Factory worker
11. Industry or business

FATHER
12. Name: David J. Williams
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Moore
15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/8/48 (month) (day) (year)
Cemetery or crematory: Statesville Cemetery
Location: York Co. Pa.

16. Funeral director: Hubert F. Hawkins
Address: Delta, Pa.

19. Jan 5 1948 (Date rec'd by registrar) C. Harry Mc... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5, 1948, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1945, to January 5, 1948 and that I last saw h... im alive on January 5 1948.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	since 11/44
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type	since 12/19

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. (M. D. or other)
Address: Sykesville, Maryland Date signed: 1/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

pc 00390

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs 1 mo 30 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 9 yrs 1 mo 30 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Zora Willoughby

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Frank Willoughby

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE:

Years	Months	Days	If less than one day
63			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: at home

FATHER — 12. Name: William Collison

13. Birthplace:

MOTHER — 14. Maiden name: Rachel Collison

15. Birthplace:

16. Informant: Frank Willoughby

Address: 3 S Highland Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-12-48 (month) (day) (year)

Cemetery or crematory: Maryland Memorial Park

Location: Balto Md.

18. Funeral director: John Ephraim

Address: 2608 Orleans St.

19. Jan. 10 1948 (Date rec'd by registrar) C. Harry Edwards Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 9th, 1948 at 11.05 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Jan 10th 1938, to Jan 9th 1948 and that I last saw h.. alive on Jan 9th 1948

Immediate cause of death	DURATION
Bronchopneumonia	1 wk
Due to	
Due to Syphilitic Meningo-Encephalitis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

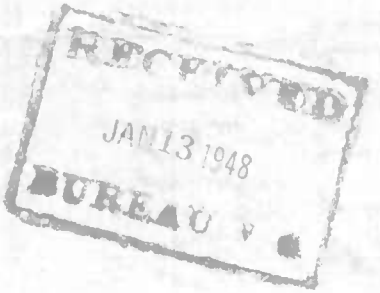
23. SIGNATURE: W. H. Haslup M.D. M. D. or other

Address: Sykesville Md. Date signed 1/9/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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JAN 13 1948
BUREAU

00391

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Route #1 Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Bruceville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Robert Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Annie Catherine Wilson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 8, 1882

8. AGE:

Years	Months	Days	If less than one day
65	11	1	hrs. min.

9. Birthplace Calvert County Md.
(Town, county, and state)

10. Usual occupation Retired night watchman

11. Industry or business Railroad Shop

FATHER

12. Name William Wilson

13. Birthplace Md.

MOTHER

14. Maiden name Agnes Modesty

15. Birthplace Md.

16. Informant Mrs. Jacob Hahn

Address Route #1 Union Bridge Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 12 1948 (month) (day) (year)

Cemetery or crematory Keysville Cemetery

Location Keysville Md.

18. Funeral director C. A. Fuss & Son

Address Taneytown Md.

Jan 11 1948 Lester D. Repp Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1948 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7 1947 to Jan 9 1948 and that I last saw h.. living alive on Jan 9 1948

Immediate cause of death

Cancer of Stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Date signed 1-9-48

W

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of birthplace shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00392

Reg. No. G 115 APR 14 1948

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos. 29 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Ward Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Wayne Wilson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 11 — 1947

8. AGE: Years — Months 4 Days 29 If less than one day ..... hrs. ..... min.

9. Birthplace Westminster Md. Hanover, Pa.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Robert E. Wilson
13. Birthplace Md.

MOTHER
14. Maiden name Helen A. Powell
15. Birthplace Pleasant Valley, Md.

16. Informant Mr Milton Powell
Address Pleasant Valley, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1948 (month) (day) (year)
Cemetery or crematory Pleasant Valley Cem.
Location Pleasant Valley, Md.

18. Funeral director H Bankard Sons
Address Westminster, Md.

19. 1/11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10th 1948 at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1948 to Jan 10 1948 and that I last saw him alive on Jan 10, 1948

Immediate cause of death	DURATION
Acute cardiac Dilatation	1 hr
Due to Broncho Pneumonia	1 day
Due to Influenza	2 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

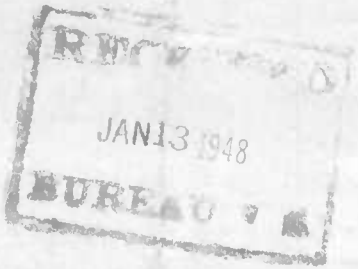
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R Fout MD
M. D. or other
Address Westminster Md. Date signed 1-10-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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